**CONSENT**

1. **Do you agree to Case Management services?**
   - Yes
   - No

2. **Do you agree to discuss your child’s health information with me today?**
   - Yes
   - No

3. **Does the member or legal guardian give verbal permission to discuss PHI?**
   - Yes
   - No

4. **Does member or authorized legal representative give verbal permission to share the results of this assessment verbally and/or electronically with members of the healthcare team?**
   - Yes
   - No

**PROMPTS**

5. **PROMPT: Verify and update race, ethnicity and language in member details**
   Use Quick Links to navigate to Member Details

6. **PROMPT: Enter member height, weight and BMI in health indicators.**
   Use Quick Links to navigate to health indicator

**OVERALL HEALTH**

7. **How would you describe your child’s health?**
   - Excellent
   - Good
   - Fair
   - Poor

8. **What concerns do you have regarding your child’s health?**
   Describe Concerns

9. **Does your child’s health keep him/her from doing the things he/she wants?**
   - Yes
   - No

**SOCIAL DETERMINANTS**

10. **Do you have difficulties (such as transportation, making appointments) that keep you from seeing your PCP or other type of needed provider as frequently as you would like to?**
    - Yes
    - No

11. **If yes, why?**
    - Transportation
    - Difficulty making or getting an appointment
    - Cannot afford copay
No PCP
Language barrier
Other
Describe Other Difficulties

12 Do you believe your child's needs are being met through your current support system, i.e. friends, family, faith organization?
Yes
No

CAREGIVER
13 Do you feel the primary caregiver is capable and adequately trained to provide necessary care? OR As the primary caregiver, do you feel adequately trained to provide necessary care? (Phrasing dependent on response to Q3)
Yes
No

14 Caregiving can certainly become overwhelming. What aspects are you finding most stressful lately? (Please select all that apply)
Not having enough time for myself
Not having enough time with others in my life
Controlling my frustration or anger regarding caregiver responsibility
Feeling out of control
Worsening condition of child
Other
Specify Other

15 Do you have any of the following concerns about your child?
Change in ability to complete ADLs (in past 90 days)
Change in mental status (in past 90 days)
Safety in his/her residence
Self-injurious behavior
Threatening behavior/ violence toward others
Wandering/Elopement
None

HEARING
16 Is your child deaf or do they have serious difficulty hearing?
Yes
No

VISION
17 Is your child blind or does he/she have serious difficulty seeing, even when wearing glasses?
Yes
No

COGNITION
18 Does your child have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
Yes
No
ADLs
19  Does your child have serious difficulty walking or climbing stairs? (5 years old or older)
   Yes
   No
20  Does your child have difficulty dressing or bathing? (5 years old or older)
   Yes
   No
21  Does your child have difficulty doing errands alone such as visiting a doctor's office, shopping, using the telephone, managing your medication? (15 years old or older)
   Yes
   No

MEDICATION
22  Does your child take prescription medications?
   Yes
   No
23  Does your child take their medication as prescribed by the doctor?
   Yes
   No
24  What prevents your child from taking his/her medications as often as prescribed by the doctor?
   Can't get to pharmacy
   Can't get approved for coverage or excluded in their plan
   Can't afford
   Experiencing side effects or don't like the way it makes me feel
   Forgets to take almost every day
   Lack of understanding/knowledge
   Hard to keep tracks of multiple medications
   Other
   Describe Other

HOUSING
25  What is your child's current living environment?
   Family Residence
   Foster Care/Medical Foster Care
   Group Home
   Long Term Care Facility
   Shelter
   Residential Treatment Center
   Rehabilitation Facility
   Other
   Describe Other

ADVANCED DIRECTIVES
26  Have you completed any of the following with or on behalf of your child?
   Advance Directive
   Psychiatric Advance Directive
   Power of Attorney
   Living Will
27 Are you interested in receiving some information to review to discuss with your family/child?  
Yes  
No  
Not Now  

28 Do you have any beliefs that impact how care should be provided for your child? (e.g., religious or other feelings and beliefs, such as blood transfusions)  
Yes  
Describe Beliefs  
No  

29 Do you have the support available to ensure your preferences are met?  
Yes  
No  

BENEFIT KNOWLEDGE  
30 Do you know what your health plan covers for you?  
Yes  
No  

EDUCATION  
31 Over the past year, how many days did the member miss preschool/school/work because of illness or injury?  
0-5 days  
6-10 days  
>10 days  
N/A (does not attend school or work)  

32 What are the reasons the member missed preschool/school/work?  
Illness  
Transportation  
Skilled nursing unavailable  
Classroom aide unavailable  
Parent/Natural Support unable to accompany child  
Hospitalization  
Child refusal  
Disciplinary action  
Behavioral health issue  
Scheduled medical/dental appointments  
Other  
Describe Other Reasons  

PHYSICAL ACTIVITY  
33 During the past week, on how many days did your child exercise or participate in any physical activities for at least 20 minutes?  
No days per week  
1-2 times per week  
3 or more times per week  
Doesn’t know
Not applicable

TOBACCO
34 Does anyone in your household smoke tobacco products?
   Yes
   No
35 Does the member smoke or use tobacco products?
   Yes
   No
   N/A

HIGH RISK BEHAVIORS
36 Is the member sexually active?
   Yes
   No
   N/A
37 Does the member use alcohol or drugs?
   Yes
   No
   N/A

INFANT
38 Is baby being breast fed?
   Yes
   No
   N/A
39 Is baby experiencing any problems with feeding?
   Yes
   No
   N/A
40 If yes, specify:
   Poor nippeling, takes too long to eat
   Problems nursing
   G-tube fed
   Problems breathing with feeds, nasal flaring, cyanosis
   Gastroesophageal Reflux (GERD) - usually on anti-reflux medication
41 Does baby have any breathing problems?
   Yes
   No
   N/A
42 If yes, describe:
   On supplemental oxygen
   On apnea monitoring
   Cyanosis
   Fast breathing
   Ventilator / Bipap
TRAUMA
43 Has the child experienced or witnessed an event that caused, or threatened to cause, serious harm to him or herself or to someone else?
   Yes
   No

44 What was the event?
   Car or Other Accident
   Fire
   Storm
   Physical Illness or Assault
   Sexual Assault
   Other Event
   Describe Other Event

45 What age was the member when this event occurred?
   Specify Age

46 Child reports more physical complaints such as headaches, stomach aches, nausea when reminded of the event.
   Not True (as far as you know)
   Somewhat or Sometimes True
   Very True
   Often True

47 Child avoids doing things that remind him/her of the event
   Not True (as far as you know)
   Somewhat or Sometimes True
   Very True
   Often True

48 Child startles easily (jumps when hears sudden loud noises)
   Not True (as far as you know)
   Somewhat or Sometimes True
   Very True
   Often True

49 Child gets upset if reminded of the event.
   Not True (as far as you know)
   Somewhat or Sometimes True
   Very True
   Often True

HEDIS
50 Are your child’s well Child check-ups (EPSDT) up to date?
   Yes
   No
   Don’t know

51 Are your child’s immunizations up to date?
   Yes
   No
   Don’t know

DENTAL
52 Does your child see the dentist for routine preventive services every 6 months?
HEDIS
53 Have you/ your child received age appropriate Health Education at each visit?
   Yes
   No
   Don't know

DISASTER PLAN
54 Do you have a plan in place to continue your care in the event of a disaster (such as hurricane, tornado, house fire, flood or snowstorm)?
   Yes
   No
55 If yes, what is your plan
   Will be staying home
   Have plan for escape
   Will be going to stay with family
   Have generator back up power source
   Will be going to shelter
   Other
   Describe Other Plan

EDUCATION
56 Does your child receive any of the following services in community early intervention program or in the school?
   Guidance Counseling
   Personal Care Attendant
   Medication Administration
   Physical Therapy
   Occupational Therapy
   Speech Therapy
   Respiratory Therapy
   Behavioral Management Services
   Individual Behavioral Health Therapy
   Group Behavioral Health Therapy
   Homebound Services
   Extended School Year Program
   Assistive Technology
   Autism Resource Services
   Visual Impairment Support
   Multiple Disabilities Support
   Other
   Please specify other services through school
   Doesn't know
   None of the above

57 Does your child have a formal plan for receiving services in the community/ school?
   Yes
   No
   Doesn't know

58 Which plan does your child have for school services?
   Individualized Family Service Plan (IFSP)
   Individualized Education Plan (IEP)
   504 Plan

59 What is the name of the coordinator who helped you create the service plan for school or early intervention services?
Enter Document name, agency and contact info
Document Name

60 Is your child’s primary care doctor involved with the IEP / IFSP/504 Plan?
   Yes
   No
   Doesn’t know

61 Are there any concerns you have regarding the services your child receives at school?
   Yes
   No
   Doesn’t Know
   N/A

CONDITIONS

62 Have you ever been told your child has one or more of the following medical conditions?

Pediatric Core Health Conditions

a. Allergies
b. Pain
c. Immune System (Body’s Defense System)
   i. Immune Globulin Deficiency (decreased ability to fight disease), Rheumatoid Arthritis
      (inflammatory disorder of joints)
d. Neurologic (Brain and Nervous System)
   i. Cerebral Palsy, Hydrocephalus (fluid build-up in brain)/VP Shunt, Paraplegia, Quadriplegia,
      Seizure Disorder/Epilepsy, Spina Bifida (spinal cord fails to develop or close properly), Spinal
      Cord Injury, Traumatic Brain Injury (TBI)
e. Head, Ear, Nose, Throat
   i. Cleft Lip/Palate, Cochlear Implant, Ear Infections, Hearing Impairment, Sinus Problems,
      Throat Infections
f. Eyes/Vision
   i. Strabismus/Lazy Eye, Vision Impairment
g. Dental
   i. Broken Teeth, Bruxism (teeth grinding), Caries, Missing Teeth, Orthodontia
h. Endocrine (Hormones/Glands)
   i. Diabetes Type 1, Diabetes Type 2. Gigantism/Acromegaly, Hypothyroidism, Short
      Stature/Dwarfism
i. Pulmonary (Lungs)
   i. Asthma, Brochopulmonary Dysplasia (BPD), Bronchiolitis/Bronchitis, Cystic Fibrosis,
      Recurrent Pneumonia, RSV, Tuberculosis
j. Cardiac/Circulatory (Heart, Circulatory System)
   i. Atrial Septal Defect (ASD), Cardiomyopathy (heart disease), Coarctation of Aorta (narrowing
      of aorta), Double outlet Rt. Ventricle, Dysrhythmias, Heart Murmur, HF (Heart Failure),
      Hypertension (high blood pressure), Hypoplastic Left Heart, Primary Pulmonary
      Hypertension, Tetralogy of Fallot, Ventricular Septal Defect (VSD)
k. Blood Disorders
   i. Hemophilia, HIV/AIDS, Sickle Cell Disease
l. Eating Disorders
   i. Anorexia, Bulimia, Eating Disorder, Failure to Thrive (inadequate weight gain)
m. Gastro-Intestinal (Esophagus, Stomach, Intestines)
   i. Gastrostomy Tube (feeding tube), Gastrostomy-Jejunostomy Tube (feeding tube),
      Obesity/Overweight, Acid Reflux, Colostomy (surgically placed exit for waste in the lower
      abdomen), Celiac Disease (immune reaction to gluten), Constipation, Crohn’s Disease
      (inflammatory bowel disease), Diarrhea, GI Motility Disorder, Hepatitis (liver inflammation),
      Hirschsprung’s Disease (condition related to difficulty passing stool), Irritable Bowel
      Syndrome, Lactose Intolerance, Neurogenic Bowel (lack of nervous control to bowel), Pyloric
      Stenosis (thickening between stomach and small intestine)
n. **Genito-Urinary** (Reproductive, Urinary, Genitals)
   i. Enuresis (urinary incontinence), GU Reflux, Neurogenic Bladder (lack of nervous control to bladder), Recurrent Urinary Tract Infections, Renal Failure, Urinary Incontinence, Pregnant, Sexually Transmitted Disease (STD)

o. **Orthopedic/Muscular** (Bone and Muscle Disorders)
   i. Amputation, Club Foot, Congenital Hip Dysplasia, Muscular Dystrophy (weakness and loss of muscle mass), Osteomyelitis (bone infection), Scoliosis (spinal curvature)

p. **Psychiatric/Behavioral Health**
   i. Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Auditory Processing Disorder, Autism or Autism Spectrum Disorder, Bipolar Disorder, Delay in Toilet Training, Depression, Post Traumatic Stress Disorder, Oppositional Defiance Disorder, Schizophrenia, Substance Abuse

q. **Other**
   i. Specify Other Condition

Allergies
Cleft Lip/Palate
Cochlear Implant
Ear Infections
Hearing Impairment
Sinus Problems
Strabismus/Lazy Eye
Throat Infections
Vision Impairment
Broken Teeth
Bruxism
Caries
Missing Teeth
Orthodontia
Pain
Atrial Septal Defect (ASD))
Cardiomyopathy
Coarcotion of Aorta
Double outlet Rt. Ventricle
Dysrhythmias
Heart Murmur
HF
Hypertension
Hypoplastic Left Heart
Primary pulmonary hypertension
Tetralogy of Fallot
Ventricular Septal Defect (VSD)
Asthma
Bronchopulmonary Dysplasia (BPD)
Bronchiolitis/Bronchitis
Cystic Fibrosis
Recurrent Pneumonia
RSV
Tuberculosis
Hemophilia

HIV/AIDS
Immune Globulin Deficiency
Rheumatoid Arthritis
Sickle Cell Disease
Diabetes Type I
Diabetes Type II
Gigantism/Acromegaly
Hypothyroidism
Short Stature/ Dwarfism
Cerebral Palsy
Hydrocephalus/VP Shunt
Paraplegia
Quadriplegia
Seizure disorder/Epilepsy
Spina Bifida
Spinal Cord Injury
Traumatic Brain Injury (TBI)
Anorexia
Bulimia
Eating Disorder
Failure to Thrive
Gastrostomy Tube
Gastrostomy-Jejunostomy Tube
Obesity/Overweight
Acid Reflux
Colostomy
Celiac Disease
Constipation
Crohn’s disease
Diarrhea
GI Motility Disorder
Hepatitis
Hirschsprungs Disease
Irritable Bowel Syndrome
Lactose Intolerance
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<td>Delay in Toilet Training</td>
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<td>Depression</td>
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<tr>
<td>Specify Other Condition</td>
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**CONSENT**

63 Are you ok if we share the information we discussed today with your child's doctor and others who may be involved in your child's care?

- Yes
- No

**CASE MANAGER**

64 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member can do the things they need to do to take care of their health?

- Extremely
- Quite a bit
- Somewhat
- A little bit
- Not at all

65 ONLY need to ask the member this question directly if Case Manager is uncertain at this point in the assessment. How confident are you, as the Case Manager, that this member will ask their provider questions and bring up their concerns?

- Extremely
- Quite a bit
- Somewhat
- A little bit
- Not at all

66 **End of assessment**